CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE

BOARD OF MENTAL HEALTH AND CHEMICAL DEPENDENCY PROFESSIONALS

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

APPLICATION FOR LICENSURE AS AN ASSOCIATE ART THERAPIST
INSTRUCTION SHEET

Before completing the application for licensure as an Associate Art Therapist (LAAT), both you, as the applicant and your supervisor should carefully read this entire instruction sheet, including the art therapy experience and supervision requirements explained below. The hours of experience and supervision are documented on the **PLANNED DIRECT SUPERVISION** and **PLANNED PROFESSIONAL ART THERAPY EXPERIENCE** forms in the application.

Associate Art Therapist
POST-MASTERS ART THERAPY EXPERIENCE REQUIREMENTS

When applying for licensed Associate Art Therapist (LAAT), you must provide a written plan for acquiring the experience required in the Board's Rules and Regulations. Your proposed supervisor must sign the plan.

Definitions to Understand

- *Supervised art therapy experience* must involve providing face-to-face art therapy services with clients and other matters directly related to treating clients in a setting that is clearly designated to provide opportunities for clinical treatment through art therapy as defined in 24 *Del C*. § 3061 and 3062.

  ***Art teaching is not considered art therapy and cannot be used toward supervised experience*.**

- *Direct supervised experience* means face-to-face consultation, on a regularly scheduled basis between a supervisee and a Licensed Professional Art Therapist (LPAT) or other Board-approved behavioral health professional. The Board-approved supervisor is responsible for ensuring that the extent, kind, and quality of the services rendered are consistent with the supervisee's education, training, and experience. (24 *Del C*. § 3060(6), Section 7.4.1)

- An *approved supervisor* must
  - be a Professional Art Therapist licensed in any jurisdiction (state, U.S. territory, District or Columbia) or a person who holds either the Registered and Board Certified Art Therapist or the Art Therapy Certified Supervisor credential from the Art Therapy Credentials Board (ATCB)
  - have no more than ten supervisees at a time

Requirements for Supervision by an Individual *not* Listed Above

- The Board may approve other licensed behavioral health professionals such as licensed marriage and family therapists, professional counselors of mental health, clinical psychologists, clinical social workers, physicians, and advanced practice registered nurses with a specialty or expertise in a clinical competency essential to your training.

- If your proposed supervisor is not licensed by the Delaware Board of Professional Counselors of Mental Health and Chemical Dependency Professionals, the proposed supervisor must
  - attest that he/she
    - has read and is familiar with the Delaware licensure requirements, including the applicable statutes, rules and regulations
    - has the training to provide clinical supervision
  - have practiced at least two years post-licensure
  - not have received any disciplinary actions
  - *will be required to provide an official verification of professional licensure for each jurisdiction*

Associate Art Therapist
POST-MASTERS ART THERAPY EXPERIENCE REQUIREMENTS
(continued)

Breakdown of Hours of Art Therapy Experience Under Direct Supervision

You must provide verification that you have completed a total of ***at least 1,600 hours*** of ***post-Masters art therapy experience*** while under the ***direct supervision*** of one or more ***approved clinical supervisors***. You are permitted to have more than one supervisor.

- At least 1,500 of the 1,600 hours must be actual face-to-face direct art therapy services. Of the 1,500 hours, at least 750 hours must be individual face-to-face client sessions and must include providing direct art therapy services. The other 750 hours may be individual, group, couple or family art therapy services or some combination of those services.
- At least 100 of the 1,600 hours must be face-to-face professional direct supervision with your supervisor. Face-to-face supervision includes both in-person and live video conferencing providing supervision by live video conferencing does not exceed 50 hours.
    - Individual direct supervision must consist of one-to-one, face-to-face meetings between you and your supervisor. All 100 hours may be individual supervision.
    - Group supervision must consist of face-to-face meetings between you and your supervisor with no more than six supervisees. You may apply no more than 40 hours of group supervision towards the 100 hours of direct supervision.
- ***You must complete all*** **of the required hours in a period of not less than two but no more than four years.**

Art Therapy Experience *Not* Under Direct Supervision

Art therapy experience hours ***not*** completed under the supervision of an individual who meets the acceptable or proposed supervisor requirements above will count only toward 1,600 hours of unsupervised experience and ***not*** toward the required 1,500 hours of supervised experience.

For more information about the experience requirements, see Section 7.3 of the Board's Rules and Regulations.

Requirements for All Applications

Both you and your supervisor(s) should carefully follow the instructions for completing the forms. *Incomplete or incorrectly completed forms delay processing of the application*. The Board will *not* accept a resume in lieu of or in addition to the forms.

☐ Submit completed, signed and notarized *Application for Licensed Associate Art Therapist.*
- Applications that are incomplete, unsigned or not notarized will be rejected.

☐ Enclose the non-refundable processing fee by check or money order made payable to the "State of Delaware."
- Applications not accompanied by the required fee will be rejected.

☐ Complete the *Criminal History Record Check Authorization* form to request State of Delaware and Federal Bureau of Investigation criminal background checks. Follow the instructions on the form to arrange to be fingerprinted.

☐ Arrange for the Board office to receive a verification of licensure from each jurisdiction (state, U.S. territory, District of Columbia) where you now hold, or have *ever* held a license to practice as an art therapist.
- You may use the *Verification of Licensure* form included with the application to request the verification.

☐ Arrange for your college/university to send an official transcript *directly* to the Board office.

☐ Documentation of your coursework is needed when your graduate program of studies is *not* in the discipline of art therapy. If you do ***not*** have a Master's or Doctoral degree in art therapy, you must show that the degree in which you received encompasses the nine areas listed on the *Evaluation of Coursework form.* Submit the following:
- completed *Evaluation of Coursework* form (included with the application)
- course catalog or course descriptions

☐ Arrange for your *approved clinical supervisor(s),* under whose supervision you will complete the required hours, to complete the form entitled **PLANNED DIRECT SUPERVISION**.

- For details on post-Masters professional art therapy experience, see the inset entitled Post-Masters Art Therapy Experience Requirements.

☐ Arrange for an *administrative supervisor* to complete the form entitled **PLANNED PROFESSIONAL ART THERAPY EXPERIENCE** to verify the hours of post-Master's art therapy experience that you will receive while ***not*** under the direct supervision of an approved clinical supervisor. If you will have more than one period of experience, arrange for a separate box to be completed for each period of experience.

☐ If you have never been issued a U.S. Social Security Number (SSN), submit a *Request for Exemption from Social Security Number Requirement*.

The Privacy Act of 1974, Section 7, requires the following information to be given to all applicants: Applicants for any Delaware professional or occupational license, permit, registration or certificate (other than Gaming permits) are required to provide a U.S. SSN (29 *Del. C.* §8735(m)). The Division of Professional Regulation uses the SSN primarily to verify identity and safeguard personal information. It may also be used to enforce child support obligation (13 *Del. C.* §2215) and for other lawful purposes.

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APPLICATION FOR LICENSED ASSOCIATE ART THERAPIST

IDENTIFYING AND CONTACT INFORMATION

1. Full Name: _____ _____ _____
   Last First Middle

2. Other Names Used: _____ _____ _____ None ☐
   (Include maiden, prior married, alternate spellings)

3. Date of Birth (month/day/year): _____ Gender: Male ☐ Female ☐

4. Have you been issued a U.S. Social Security Number? Yes ☐ No ☐ **If yes, enter your SSN:** _____
   If no, you must file a *Request for Exemption from Social Security Number Requirement*.

5. Mailing Address: _____

   _____ _____ _____
   City State Zip

6. Phone: _____ _____ Email: _____ None ☐
   Home Work

LICENSURE HISTORY – *All* applicants complete this section.

7. Has any jurisdiction ever denied your application for licensure? Yes ☐ No ☐ If yes, explain fully**:** _____

   _____

8. Have you ever held any license type to practice as an art therapist in any jurisdiction other than Delaware?
   Yes ☐ No ☐ If yes, enter the following information about *each* art therapist license that you have *ever* held.

JURISDICTION	TYPE OF LICENSE HELD	LICENSE NUMBER	LICENSURE DATES	
			From	To

Arrange for the Board office to receive a verification of licensure from *each* jurisdiction where you have *ever* held a license to practice as an art therapist.

GRADUATE EDUCATION

9. Enter this information about the program from which you received your highest degree.

   Highest Degree Received: _____ Degree Date: _____

   School Name: _____

   Address: _____ _____ _____ _____
   Street City State Zip

   Arrange for the college or university to send an official transcript *directly* to the Board office.

10. Select the type of degree you received (check one):

   ☐ Doctoral degree in art therapy from an accredited institution. Continue to the **PLANS FOR DIRECT SUPERVISION AND PROFESSIONAL ART THERAPY EXPERIENCE** section.

   ☐ Master's degree in art therapy from an accredited institution. Continue to the **PLANS FOR DIRECT SUPERVISION AND PROFESSIONAL ART THERAPY EXPERIENCE** section.

   ☐ Neither of the above. Your degree must meet the criteria of the nine content areas per the Board's Rules and Regulations (Section 7.1.1). **Submit the**
   - **completed *Evaluation of Coursework* form**
   - **course catalog or course descriptions.**

PLANS FOR DIRECT SUPERVISION AND PROFESSIONAL ART THERAPY EXPERIENCE

11. Is your clinical supervisor a Licensed Professional Art Therapist in any state or U.S. territory or an individual holding either the Registered and Board Certified Art Therapist or Art Therapy Certified Supervisor credential from the Art Therapy Credentials Board (ATCB)? Yes ☐ No ☐ **If no, explain *in detail* (1) the steps you took to secure a licensed Professional Art Therapist, Registered and Board Certified Art Therapist, or an Art Therapy Certified Supervisor to supervise you and (2) a compelling clinical reason why you are proposing another professional as your supervisor.**

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

   _____

12. On the next pages, provide the requested information about the direct clinical supervision and/or unsupervised art therapy experience that you will be completing as follows:

   - Arrange for your *clinical* supervisor to complete and sign the form entitled **PLANNED DIRECT SUPERVISION** to verify the hours of post-Master's ***direct supervision*** that you will receive. If you will receive direct supervision in more than one period under different supervisors, have the approved clinical supervisor for each period complete a form for the period during which he or she will supervise you.
   - Arrange for an *administrative supervisor* to complete the form entitled **PLANNED PROFESSIONAL ART THERAPY EXPERIENCE** to verify the hours of post-Master's art therapy experience that you will receive while ***not*** under the direct supervision of an approved clinical supervisor. If you will have more than one period of experience, arrange for a separate box to be completed for each period of experience.

PLANNED DIRECT SUPERVISION – To be completed by *Clinical* Supervisor only

INSTRUCTIONS

The proposed clinical supervisor completes this PLANNED DIRECT SUPERVISION form to document hours that he or she will be directly supervising an Licensed Associate Art Therapist (LAAT). According to the LAAT regulations:

- *Direct supervision* is overseeing the LAAT's application of clinical appraisal and treatment activities during individual, couples, family, or group sessions which provide opportunities for clinical treatment through art therapy. *Individual supervision* is one-to-one, face-to-face, meetings between the supervisor and LAAT. *Group supervision* is face-to-face meetings between supervisor, LAAT, and up to six supervisees.
- The applicant must complete a total of ***at least 1,600 hours*** of ***post-Masters art therapy experience*** while under the ***direct supervision*** of one or more ***approved clinical supervisors***.
  - At least 1,500 of the 1,600 hours must be actual face-to-face direct art therapy services. Of the 1,500 hours, at least 750 hours must be individual face-to-face client sessions and must include providing direct art therapy services. The additional 750 hours may be individual, group, couple or family sessions or some combination of those services.
  - At least 100 of the 1,600 hours must be face-to-face professional direct supervision with the applicant's supervisor. All of the 100 hours of direct supervision under all approved clinical supervisors must be face-to-face one-on-one – that is, the applicant and applicant's supervisor. Individual supervision may fulfill the entire 100-hour requirement. No more than 40 of the 100 hours may be in a group setting – that is, the applicant, the supervisor, and up to six LAAT supervisees.
- **The LAAT must complete *all* required hours, whether or not directly supervised, in a period of not less than two but no more than four years**.

Applicant Name: _____ _____ _____
Last First Middle

INFORMATION ABOUT CLINICAL SUPERVISOR

1. Supervisor Name: _____ _____ _____
Last First Middle

2. Are you a DE-licensed professional? Yes ☐ No ☐ If yes, enter your License Number: _____ and **SKIP** to Question 4. If no, continue to Question 3.

3. Enter the following information about your professional licensure:

✓	LICENSES OR CERTIFICATIONS HELD (check all that apply)	JURISDICATION	LICENSE OR CERTIFICATION#	ISSUE DATE	EXPIRATION DATE
☐	Professional Art Therapist				
☐	Registered and Board Certified Art Therapist				
☐	Art Therapy Supervisor Certification				
☐	Clinical Social Worker				
☐	Professional Counselor of Mental Health				
☐	Marriage and Family Therapist				
☐	Clinical Psychologist				
☐	Physician				
☐	Advanced Practice Registered Nurse				
☐	Other:_____				

4. I certify that:

☐	I have at least two years of post-licensure experience in good standing. ***Submit an official verification of your license from that jurisdiction***.
☐	I have read and understand the requirements for licensure in Delaware.
☐	I have read and understand the statutes, rules and regulations of the Delaware Board of Professional Counselors of Mental Health and Chemical Dependency Professionals, 24 *Del*. C. §3001-3054.

5. Supervisor's Practice Name (if applicable): _____

6. Practice Address: _____

_____ _____ _____
City State Zip

PLANNED DIRECT SUPERVISION, continued

7. Phone: _____ Email: _____

DIRECT SUPERVISION HOURS

8. Enter the dates of planned post-Master's clinical experience that the applicant will provide under your direct supervision: From _____ (Month/Year) To _____ (Month/Year)

This period must not span more than four years.

9. During the period entered above, how many total hours of face-to-face professional direct supervision will you provide to the applicant? _____ Of this total, enter the breakout:

   Individual supervision hours: _____ Group supervision hours: _____

10. During this period, how many hours of individual face-to-face direct client contact will the applicant provide under your direct supervision? _____ (***At least 750 of the 1,500 hours of direct art therapy experience must be individual face-to-face client sessions.)***

11. During this period, how many hours of group, couple, or family face-to-face direct client contact will the applicant provide under your direct supervision? _____ ***(Must not exceed 750 hours)***

12. Describe the clinical activities in which the applicant will participate. (Examples include clinical assessments, crisis interventions, and individual/group sessions.) _____

    _____

    _____

13. I attest that I have discussed the following with the applicant before completing this form. Answer each question***. If you answer 'NO' or 'N/A' to any question, enclose a written statement explaining why.***

I have explained to the applicant that I have the training, credentials, and competence to provide supervision in Delaware.	Yes ☐ No ☐ N/A ☐
I have discussed my role and responsibilities with the applicant. These include: • Evaluating the applicant's clinical competence and preparedness to practice independently • Ensuring that the applicant practices within the field's professional and ethical standards • Ensuring that the applicant is aware of the rules and regulations for practicing independently in Delaware	 Yes ☐ No ☐ N/A ☐ Yes ☐ No ☐ N/A ☐ Yes ☐ No ☐ N/A ☐
I have discussed a contingency plan for dealing with emergencies and crises.	Yes ☐ No ☐ N/A ☐
I have explained my model and style of supervision to the applicant.	Yes ☐ No ☐ N/A ☐
I have reviewed the supervisory feedback process, including performance appraisal, evaluation feedback, documentation, and feedback intervals.	Yes ☐ No ☐ N/A ☐
I have explained how I will assess the applicant's comprehension of ethical, legal, and professional requirements.	Yes ☐ No ☐ N/A ☐

I certify that I have personally completed this information and that the information provided herein is accurate and complete to the best of my knowledge.

***Clinical Supervisor Signature*: _____ Date: _____**

PLANNED PROFESSIONAL ART THERAPY EXPERIENCE – To be completed by *Administrative* Supervisor only

INSTRUCTIONS

An administrative supervisor completes the **PLANNED PROFESSIONAL ART THERAPY EXPERIENCE** form to document estimated additional hours of professional art therapy experience that the applicant will accrue while ***not*** under the direct supervision of an approved clinical supervisor. Remember that these additional hours, when added to the 1,600 or more hours of direct supervision verified by the approved clinical supervisor(s), must total at least 3,200 hours.

Applicant Name: _____ _____ _____
Last First Middle

INFORMATION ABOUT PERSON VERIFYING EXPERIENCE

1. Name: _____ _____ _____
Last First Middle

2. Practice Name Where Experience Will Occur: _____

3. Describe Practice: _____

_____
Examples include group practice, community mental health agency.

4. Practice Address: _____

_____ _____ _____
City State Zip

5. Phone: _____ Email: _____None ☐

EXPERIENCE HOURS

6. Enter the period when you will supervise the LAAT: From _____ To _____
Month/Year Month/Year

This period must not span more than four years.

7. Calculate and enter the total number of hours of professional art therapy experience that the applicant will engage in during this period while not under direct supervision of an approved clinical supervisor: _____

Answers such as "40 hours/week" will not be accepted.

CERTIFICATION

I certify that I have personally completed this information and that the information provided herein is accurate and complete to the best of my knowledge.

***Administrative Supervisor Signature*:** _____ Date: _____

DISCLOSURES

13. Have you received any administrative penalties regarding your actions as a licensed, registered or certified art therapy provider, including but not limited to fines, formal reprimands, license suspensions or revocation (except for license revocations for nonpayment of license renewal fees), probationary limitations, and/or have you entered into any "consent agreement" which contains conditions placed by a Board on your professional conduct, including any voluntary surrender of a license? Yes ☐ No ☐ **If yes, enclose a detailed explanation of all such penalties.**

14. Are any disciplinary actions pending against you? Yes ☐ No ☐ **If yes, enclose a detailed explanation of any pending actions.**

15. Have you done any of the following grounds for discipline:
    - committed or knowingly cooperated in a fraud or material deception in order to acquire a license? Yes ☐ No ☐
    - impersonated another person holding a license? Yes ☐ No ☐
    - allowed another person to use your license? Yes ☐ No ☐
    - aided or abetted an unlicensed person to represent himself or herself as a licensee? Yes ☐ No ☐

    If yes to *any*, enclose a detailed explanation of the violations.

16. Have you engaged in an act which involved consumer fraud or deception, restraint of competition, or price fixing? Yes ☐ No ☐ **If yes, enclose a detailed explanation.**

17. Do you have any impairment related to drugs or alcohol or a finding of mental incompetence by a physician that would limit your ability to act as a professional art therapist or an associate art therapist in a manner consistent with the safety of the public? Yes ☐ No ☐ **If yes, enclose a detailed explanation.**

18. Have you been penalized for any willful violation of the principles of the ATCB Code of Ethics, Conduct, and Disciplinary Procedures or other seminal professional art therapy standards? Yes ☐ No ☐ **If yes, enclose a detailed explanation.**

19. Are you presently in violation of any Rule and Regulation set forth by the Delaware Board of Mental Health and Chemical Dependency Professionals? Yes ☐ No ☐ **If yes, enclose a detailed explanation of all such violations.**

Complete the Criminal History Record Check Authorization form to request State of Delaware and Federal Bureau of Investigations criminal background checks. Follow the instructions on the form to arrange to be fingerprinted.

DUTY TO REPORT

20. To obtain a license in Delaware, you must certify that you understand that you have a ***mandatory*** duty to report, in writing, within 30 days of becoming aware of information that you reasonably believe indicates that ***any healthcare provider*** including (but not limited to) any practitioner certified and registered to practice medicine in Delaware or licensed by the Board of Mental Health and Chemical Dependency Professionals
    - has engaged, or is engaging, in conduct that would constitute grounds of discipline under their licensing laws, or
    - may be unable to practice with reasonable skill and safety to the public by reason of mental illness or mental incompetence, physical illness (including deterioration through the aging process or loss of motor skill), or excessive abuse of drugs (including alcohol).

    I certify that I have read and understand 24 *Del. C*. §3018, and that I understand my *duty to report* to the Division of Professional Regulation. Yes ☐ No ☐

21. To obtain a Delaware license, you must certify that you understand that you have a ***mandatory*** obligation to make an immediate oral report to the Department of Services for Children, Youth and Their Families if you know of, or you suspect, child abuse or neglect under Chapter 9 of Title 16 and to follow up with any requested written reports.

    I certify that I have read and understand 16 *Del. C*. §903 and that I understand my *duty to report*. Yes ☐ No ☐

22. To obtain a Delaware license, you must certify that you understand that you have a ***mandatory*** duty to **self report** when your license to practice in another jurisdiction has been disciplined, surrendered, suspended or revoked.

    I certify that I have read and understand 24 *Del. C*. §3009 (a)(7) and that I understand my *duty to self report*. Yes ☐ No ☐

    To ensure consideration of your license application at the next Board meeting, the Board office must receive all of these items no later than 4:30 PM ten full working days before the Board's meeting date:
    - **Completed, signed and notarized application form**
    - **Fee payment**
    - **All required supporting documentation.**

    Applications that are not complete within 12 months of filing may be considered abandoned and discarded.

AFFIDAVIT

The undersigned applicant for Licensed Associate Art Therapist, being sworn, deposes and affirms that he or she is the person who executed this application; that the statements contained on this application are true in every respect; that he or she has not suppressed or withheld information that might affect this application; that he or she will abide by the laws and the ethical standards of this profession; and that he or she has read and understands this statement.

The applicant further affirms that he or she has read and understands the* PLANNED DIRECT SUPERVISION and PLANNED PROFESSIONAL ART THERAPY EXPERIENCE *forms in the application and that he or she will promptly report any change in the plan to the Board office.

The applicant authorizes all jurisdictions to release any and all information regarding his/her disciplinary history and current status to the Delaware Board of Mental Health and Chemical Dependency Professionals.

Signature of Applicant: _____ Date: _____

State of _____ County of _____

Sworn to before me and subscribed in my presence this _____ day of _____2_____.

Signature of Notary: _____

SEAL

My commission expires: _____

APPLICATIONS THAT ARE UNSIGNED, NOT NOTARIZED, INCOMPLETE OR NOT ACCOMPANIED BY THE REQUIRED FEE WILL BE REJECTED.

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VERIFICATION OF LICENSE

Send a separate form to *each* jurisdiction other than Delaware where you have ever held a license to practice as a professional art therapist or associate art therapist. Before sending this form to the jurisdiction, it is advisable to find out if the jurisdiction requires a fee to provide a license verification. You may duplicate this form.

This section to be completed by applicant.	Last Name:_____ First:_____ Middle: _____ SSN:_____ Date of Birth:_____ Other Name(s) Used: _____ Jurisdiction Where Licensed: _____ License/Registration Number(s) in Jurisdiction Named Above: _____ I am applying for Delaware licensure as a: ☐ Professional Counselor of Mental Health ☐ Associate Counselor of Mental Health ☐ Marriage and Family Therapist ☐ Associate Marriage and Family Therapist ☐ Professional Art Therapist ☐ Associate Art Therapist ☐ Chemical Dependency Professional Before my application can be reviewed, verification of my license in good standing is required. I am authorizing the release of the information requested on this form to be sent to the Delaware Board of Mental Health and Chemical Dependency Professionals. **Applicant Signature:** _____ Date: _____
This section to be completed by Licensing Authority.	Our records indicate that the applicant named above was licensed in the State/Province/Jurisdiction of: _____ as a (type of license) _____ Registration/License Number: _____ Issue Date (month/day/year): _____ Expiration Date (month/day/year): _____ Has the licensee ever been subject to any disciplinary action or had his/her license revoked or suspended? Yes ☐ No ☐ **If yes, please enclose a certified copy of the board's final order with this license verification.** Are any disciplinary proceedings or unresolved complaints pending against the licensee? Yes ☐ No ☐
AFFIX OFFICIAL SEAL HERE	***I certify that the statements contained herein are true and correct.*** Printed Name of Official: _____ Signature of Official: _____ Date: _____ Title:_____ Phone: _____ Fax: _____ Email:_____

Return completed, signed and sealed form *directly* to the Board office at the address above.

Created 5/2018

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EVALUATION OF COURSEWORK

INSTRUCTIONS

Complete and submit this form if you do not have a Master's or Doctoral degree in art therapy. This applies when your

- graduate program of studies is *not* from a regionally accredited institution of higher education, *or*
- degree is *not* in art therapy but in a related discipline.

For each topic in the left column, enter the course number and title of the course(s) in the catalog that covered that topic.

The degree you obtained must encompass the nine core areas below.

ART THERAPY CORE COURSES	COURSE #	COURSE TITLE
History of Art Therapy		
Theory of Art Therapy		
Techniques of Practice in Art Therapy		
Application of Art Therapy with People in Different Treatment Settings		
Art Therapy Assessment		
Ethical and Legal Issues of Art Therapy Practice		
Matters of Cultural and Social Diversity Bearing on the Practice of Art Therapy		
Standards of Good Art Therapy Practice		
Group Art Therapy		

Submit a course catalog or course descriptions in addition to this form.

Instructions for Requesting a Criminal Background Check

Both State of Delaware and Federal Bureau of Investigation criminal background checks are required.

Applicant Notification

Your fingerprints will be used to check the criminal history records of the Federal Bureau of Investigation (FBI). You have the opportunity to challenge the accuracy of the information contained in the FBI identification record. See Title 28, CFR 16.34 for the procedure to obtain a change, correction or update in the FBI record.

Locations

Kent County – Primary Facility
State Bureau of Identification
Blue Hen Mall & Corporate Center
655 S. Bay Rd. Suite 1B
Dover, DE 19901
Walk-ins accepted: Mon 8:30 am – 6:30 pm, Tue - Fri 8:30 am – 3:30 pm
Customer Service: (302) 739-2134

New Castle County - Satellite Facility
State Police Troop Two
100 LaGrange Ave
Newark, DE 19702
(between Rts. 72 and 896 on Rt. 40)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Sussex County – Satellite Facility
Thurman Adams State Service Center
546 S. Bedford Street, Rm. 202
Georgetown DE 19947
(across from DelDOT & Troop 4)
By appointment only
Scheduling: (302) 739-2528 (local)
(800) 464-4357 (toll free)

Applicants in Delaware

1. If you are using the New Castle County or Sussex County locations, call **(800) 464-HELP (4357)** to schedule an appointment. No appointments are needed at the Kent County location.

2. Take the completed *Authorization for Release of Information* form to one of the offices listed above with the fee of $65.00, to cover both the State of Delaware and Federal Bureau of Investigation criminal checks. Money orders and credit cards other than American Express are accepted at all locations. New Castle and Kent Counties accept cash; Sussex County does not accept cash. ***Personal checks are not accepted in any county.*** As fees are subject to change, contact the agency where you plan to submit your forms for current fees.

Applicants Not in Delaware (including Out-of-State or Outside the United States)

1. Your local police agency can fingerprint you. All types of fingerprint cards are accepted. Or, you may print a FD-258 fingerprint form available on the FBI website at www.fbi.gov – click *Services*, then *Identity History Summary Checks*, then scroll down to Option 1, Step 2, and click the link for *standard fingerprint form (FD-258)*. You may print the form on regular paper.

2. Your *Authorization for Release of Information* form and the fingerprint card must be complete. If identifying information is missing (such as name, date of birth, race, gender, etc.), your form will be returned.

3. ***Mail*** the *Authorization* form, fingerprint card, and *certified* check or money order ***(personal checks are not accepted)*** for $65.00 made payable to "Delaware State Police" to:

Delaware State Police
State Bureau of Identification (SBI)
PO Box 430
Dover, DE 19903-0430

DO NOT SEND THIS FORM OR FEE TO YOUR PROFESSION'S BOARD OFFICE.

DO NOT SEND THIS FORM OR FEE TO THE DIVISION OF PROFESSIONAL REGULATION.

⇨ALLOW FOUR WEEKS FOR RECEIPT OF RESULTS.

Created 5/2018

CANNON BUILDING
861 SILVER LAKE BLVD., SUITE 203
DOVER, DELAWARE 19904-2467

STATE OF DELAWARE

TELEPHONE: (302) 744-4500
FAX: (302) 739-2711
WEBSITE: DPR.DELAWARE.GOV
EMAIL: customerservice.dpr@state.de.us

AUTHORIZATION FOR RELEASE OF INFORMATION

CRIMINAL HISTORY RECORD CHECK FOR PROFESSIONAL LICENSURE APPLICANTS

Please print or type all information in black ink.

Check the type of license for which you are applying:

- ☐ Adult Entertainment
- ☐ Charitable Gaming Vendor
- ☐ Chiropractic
- ☐ Dental
- ☐ Funeral
- ☐ Massage
- ☐ Medical (Physicians (MD, DO and Administrative Medical), Physician Assistants, Respiratory Care Practitioners, Eastern Medicine Practitioners, Acupuncture Practitioners, Genetic Counselors, Polysomnographers, Midwifery Practitioners (CM, CPM))
- ☐ Mental Health (LPCMH, LCDP, LMFT, LAPCMH, LAMFT LPAT, LAAT)
- ☐ Nursing (RN, LPN, APRN)
- ☐ Nursing Home Administrator
- ☐ Occupational Therapy
- ☐ Optometry
- ☐ Pharmacy (includes key personnel of facilities licensed by Board of Pharmacy)
- ☐ Physical Therapy/Athletic Trainer
- ☐ Podiatry
- ☐ Psychology
- ☐ Real Estate Appraiser (includes Appraisal Management Company)
- ☐ Speech/Hearing
- ☐ Social Work
- ☐ Texas Hold'em Individual

Print your current full name:

_____ _____ _____ _____
Last Name First Name Middle Initial Suffix (e.g., Jr., Sr.)

Enter all other names you have used in the past (including, but not limited to, maiden name, former married names, alternative spellings):

1. _____
2. _____
3. _____
4. _____

As an applicant, I authorize release of any and all information that you have concerning my **CRIMINAL HISTORY RECORD INFORMATION**. I hereby release you, your organization, the State of Delaware and others from any liability or damage which may result from furnishing this information:

SIGNATURE OF PERSON PRINTED: _____ **Date**: _____
Phone: Home _____ Work _____

Mail the results of my criminal history request to:

Division of Professional Regulation
861 Silver Lake Boulevard, Suite 203
Dover DE 19904
SLC D420A

USE OF CRIMINAL HISTORY RECORD INFORMATION IS RESTRICTED BY LAW AND SHALL BE LIMITED TO THE PURPOSE FOR WHICH IT WAS GIVEN. MISUSE CONSTITUTES A CRIMINAL VIOLATION.

NONCRIMINAL JUSTICE APPLICANT'S PRIVACY RIGHTS

As an applicant who is the subject of a national fingerprint-based criminal history record check for a noncriminal justice purpose (such as an application for a job or license, an immigration or naturalization matter, security clearance, or adoption), you have certain rights which are discussed below.

- **You must be provided written notification[1] that your fingerprints will be used to check the criminal history records of the FBI.**
- **If you have a criminal history record, the officials making a determination of your suitability for the job, license, or other benefit must provide you the opportunity to complete or challenge the accuracy of the information in the record.**
- **The officials must advise you that the procedures for obtaining a change, correction, or updating of your criminal history record are set forth at Title 28, Code of Federal Regulations (CFR), Section 16.34.**
- **If you have a criminal history record, you should be afforded a reasonable amount of time to correct or complete the record (or decline to do so) before the officials deny you the job, license, or other benefit based on information in the criminal history record.[2]**

You have the right to expect that officials receiving the results of the criminal history record check will use it only for authorized purposes and will not retain or disseminate it in violation of federal statute, regulation or executive order, or rule, procedure or standard established by the National Crime Prevention and Privacy Compact Council.[3]

If agency policy permits, the officials may provide you with a copy of your FBI criminal history record for review and possible challenge. If agency policy does not permit it to provide you a copy of the record, you may obtain a copy of the record by submitting fingerprints and a fee to the FBI. Information regarding this process may be obtained at http://www.fbi.gov/about-us/cjis/background-checks.

If you decide to challenge the accuracy or completeness of your FBI criminal history record, you should send your challenge to the agency that contributed the questioned information to the FBI. Alternatively, you may send your challenge directly to the FBI. The FBI will then forward your challenge to the agency that contributed the questioned information and request the agency to verify or correct the challenged entry. Upon receipt of an official communication from that agency, the FBI will make any necessary changes/corrections to your record in accordance with the information supplied by that agency. (See 28 CFR 16.30 through 16.34.)

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[1] Written notification includes electronic notification, but excludes oral notification.
[2] See 28 CFR 50.12(b).
[3] See 5 U.S.C. 552a(b); 28 U.S.C. 534(b); 42 U.S.C. 14616, Article IV(c); 28 CFR 20.21(c), 20.33(d) and 906.2(d).